

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/03/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2010	2. 2012	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/02/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/29/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/02/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2015 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 43	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/28/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2014	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2010	2. 1997	3. 2003	4. 2004	5. UNKNOWN	6. UNKNOWN

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 45	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/20/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2002 2. 2008 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/19/2015	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2009 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/03/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/28/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2000 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/20/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/03/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 4

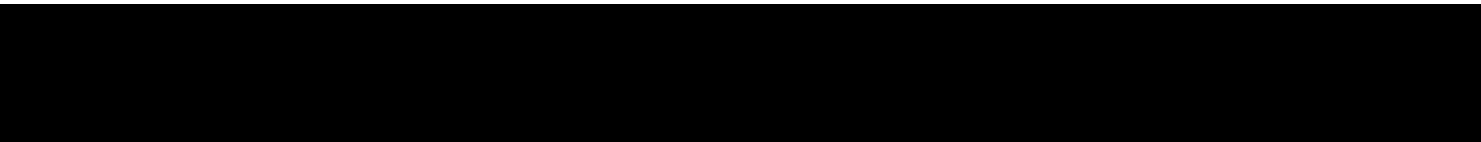
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. 01/24/2013	4. 07/10/2013	5. 03/28/2014	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 03/27/2014 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2004 2. 2011 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/13/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

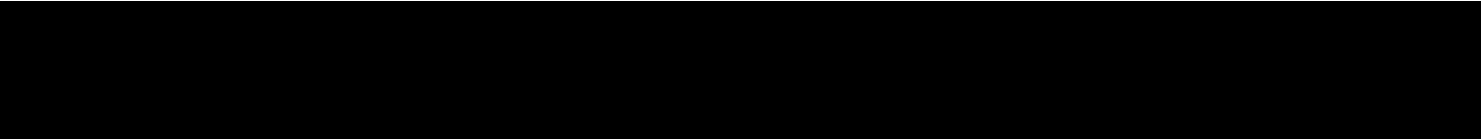
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 12/08/2011 3. 09/13/2012 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/23/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/06/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/12/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 09/13/2012 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/25/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1994 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/26/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/02/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/27/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2000 2. 2006 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/30/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 45	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Doctorate/Professional Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 04/2015 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 01/07/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/16/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1994 2. 1996 3. 2015 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 02/29/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question.</div> <div>Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions.</div> <div>Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 10/27/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 5	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/21/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/05/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/21/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/23/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2015 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/31/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. 2013 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/28/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2010 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2011	2.	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/28/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 01/16/2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/09/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 6	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2010	2.	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/12/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results: _____	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/28/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/02/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2008 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 07/09/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 2000 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/22/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 14	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 09/20/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/09/2012 2. 06/28/2012 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
---	--	--

Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/18/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/28/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/02/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/03/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2000 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/10/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 1994	2.	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 10/26/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/28/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 01/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/05/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 03/02/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/19/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2012	2. UNKNOWN	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education 8th Grade or Less
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 08/01/2013 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/30/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 6	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 2015 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/02/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

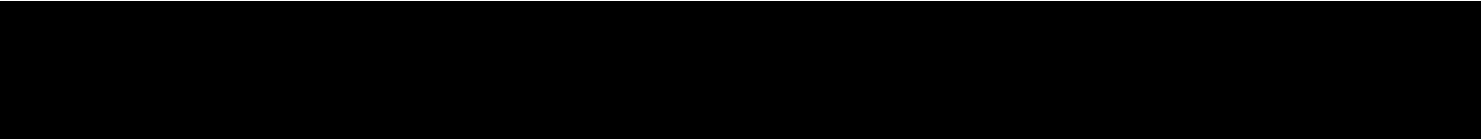
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 14	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
--	--	--

Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/09/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

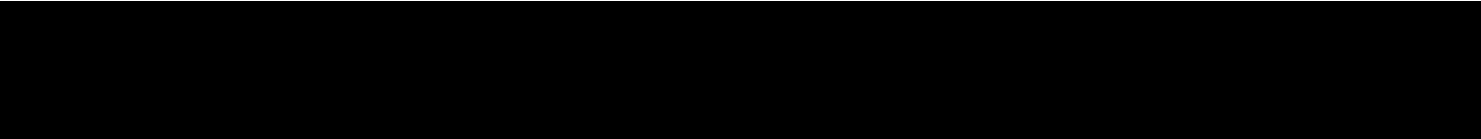
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

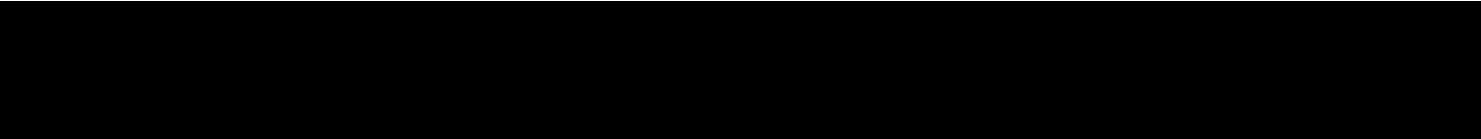
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

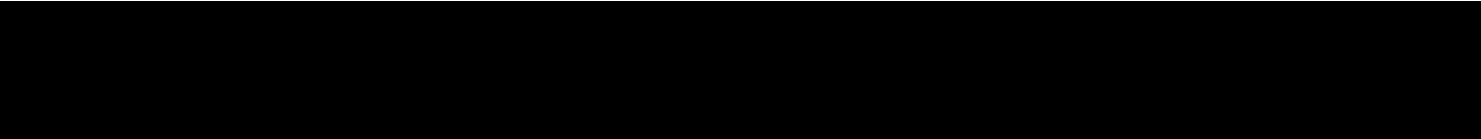
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2011	2. UNKNOWN	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/13/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/24/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 4	Number of induced terminations 3

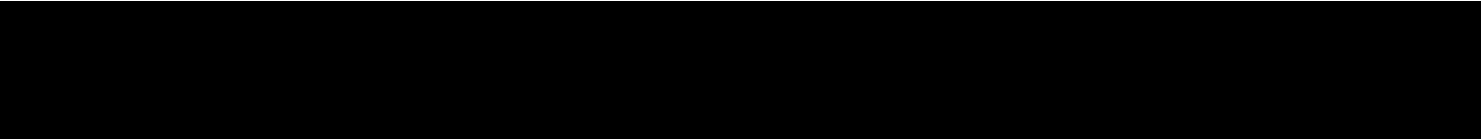
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. UNKNOWN	4. UNKNOWN	5. UNKNOWN	6. UNKNOWN

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/24/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 2
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2007 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/20/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/03/2008 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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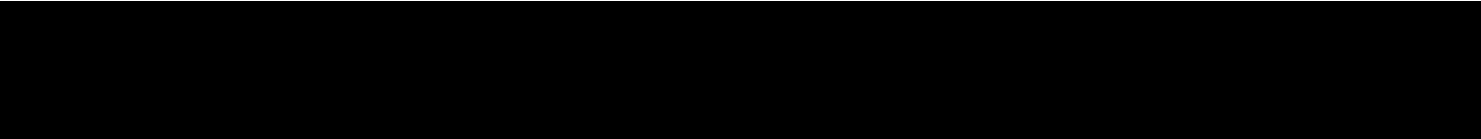
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 11/23/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/19/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/22/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2002 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Other	Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/07/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/30/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2002 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 09/28/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/01/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2.	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/21/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 6

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 11/2014	2. UNKNOWN	3. UNKNOWN	4. UNKNOWN	5. UNKNOWN	6. UNKNOWN

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/20/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/19/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 80
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 2015 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2012	2. 2013	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/01/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2003 2. 2008 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/13/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/10/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1996 2. 2014 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

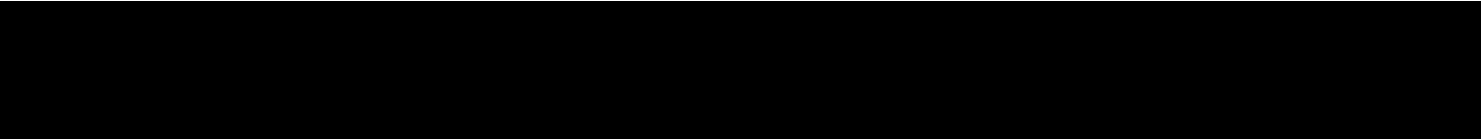
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/07/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 04/24/2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/02/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/16/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/26/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/10/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/08/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/06/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/19/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2012	2. 2013	3. 2014	4. 2015	5. 2015	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1998 2. 2000 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 44	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 11/11/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/28/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/19/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/25/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/05/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/17/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/27/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/08/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/08/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/14/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
--	--	--

Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/29/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/10/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2007 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 02/03/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1996 2. 2014 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/23/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/26/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 4	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 05/2015 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/02/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 06/2015	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 08/16/2012 2. 02/20/2013 3. 08/21/2013 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/04/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/30/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. _____	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/26/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/30/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 7	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2015 3. 2007 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 5

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (in weeks) 12	Post fertilization age of the fetus (in weeks) 10
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

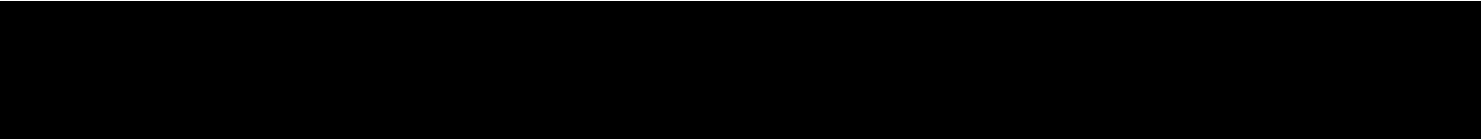
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (in weeks) 11	Post fertilization age of the fetus (in weeks) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2		Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0		Number of induced terminations 1
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 43	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/08/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/08/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1990 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/22/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/24/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/26/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input checked="" type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/23/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (in weeks) 9	Post fertilization age of the fetus (in weeks) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/17/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 7	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/19/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 2004 3. 2005 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 12/31/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/22/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2012	2. 2013	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 2010 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. UNKNOWN 3. UNKNOWN 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

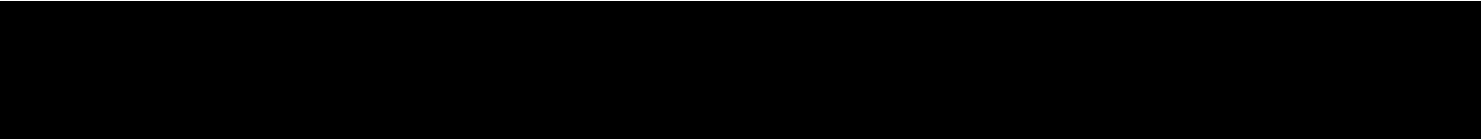
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 5

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2008	2. 2010	3. 2011	4. 2014	5. 2015	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/16/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTTA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
--	--	--

Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE DONE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/21/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/27/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
			Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 02/12/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/29/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/13/2012 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/18/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 09/24/2015 2. 02/23/2012 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/08/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/11/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/06/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2010 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____
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Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/09/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/06/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 11/15/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2007 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

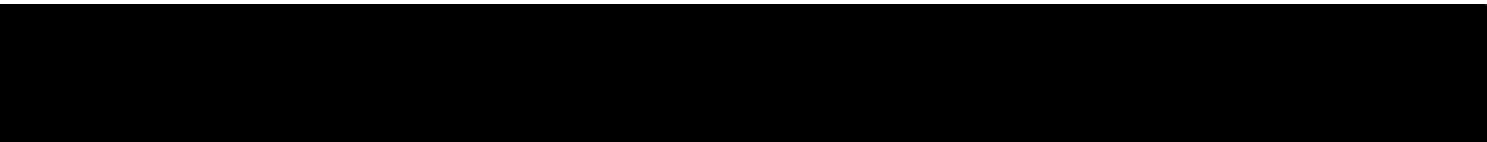
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1999 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/13/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/12/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/03/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/07/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/26/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. _____	4. _____	5. _____	6. _____

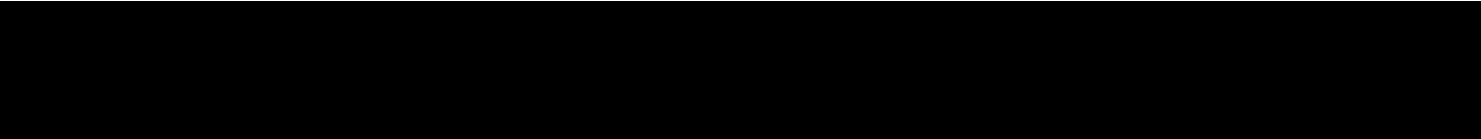
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/29/1999	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1999 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COM PLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 05/2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/11/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2015 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/30/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/28/2015	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2014 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. UNKNOWN	4. UNKNOWN	5. UNKNOWN	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/13/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2010 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/16/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.	
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/13/2015	Physician estimate of gestation (in weeks) 11	Post fertilization age of the fetus (in weeks) 9
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 3	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. UNKNOWN	4. UNKNOWN	5. UNKNOWN	6. UNKNOWN

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/04/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/29/2015	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/07/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/15/2015	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/02/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 2014 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/14/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/11/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 38	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/05/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/16/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 06/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/25/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 03/17/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 12/23/2015	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/09/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Doctorate/Professional Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2007 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2006 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/24/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 01/2016 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2014	2. UNKNOWN	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1997 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2006	2. 2007	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 08/19/2015 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/06/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/30/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2008 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2013 3. 2015 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 4	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2013 3. 2014 4. 2015 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
			Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 2007 3. 2013 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 41	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2013 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/09/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

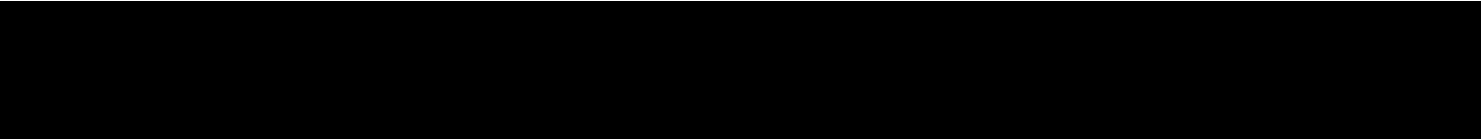
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Associate Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/26/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/27/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 4	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2011 3. 2011 4. 2012 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/02/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2000 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2015 3. 2015 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2003 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/06/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/21/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 80
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2015	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 43	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2016 2. UNKNOWN 3. UNKNOWN 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2002 2. 2015 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/21/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/29/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/19/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2000 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEEDUREMCOMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

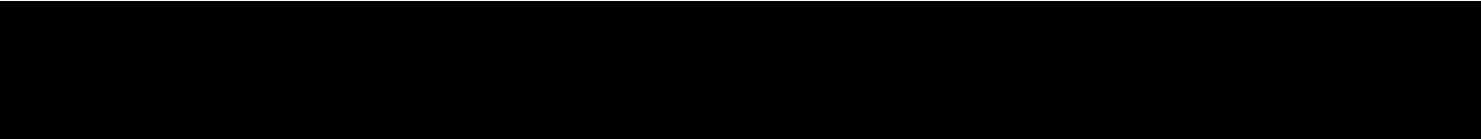
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/04/2016	Physician estimate of gestation (in weeks) 10	Post fertilization age of the fetus (in weeks) 8
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (month, day, year):

DATE RECEIVED BY ISDH (month, day, year): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/19/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTTA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 38	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/19/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 09/30/2015 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/09/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 7	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 06/1997 2. 08/1999 3. 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 12/24/2015	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/13/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2007 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2003 2. 2009 3. 2012 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/16/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/11/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

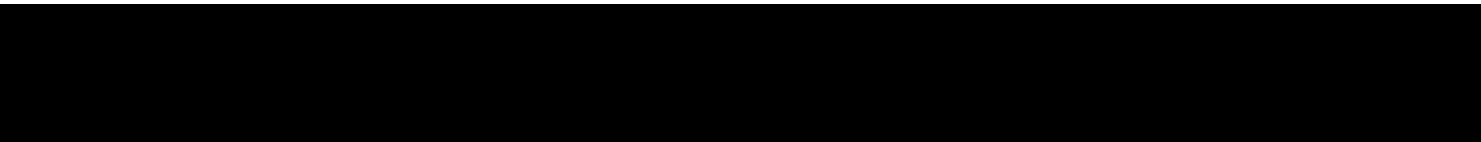
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2000 2. 2010 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/27/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 03/2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/13/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/16/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

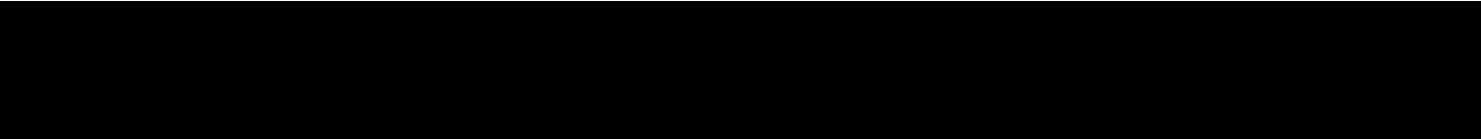
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 10/2015	2. 06/2010	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/11/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/10/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 43	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/15/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/26/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/11/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/06/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 10/2013 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/03/2016	Physician estimate of gestation (<i>in weeks</i>) 1	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/25/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/15/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/30/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

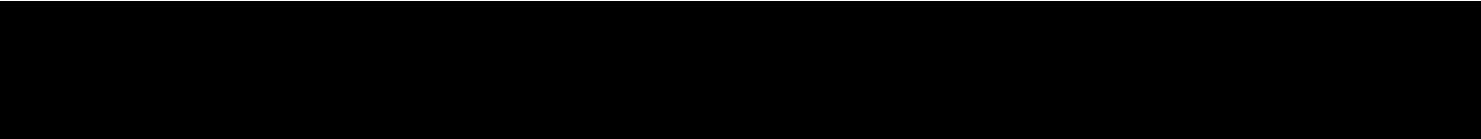
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 03/17/2016 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/23/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 2012 4. 2013 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 01/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/26/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 04/12/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 01/01/2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

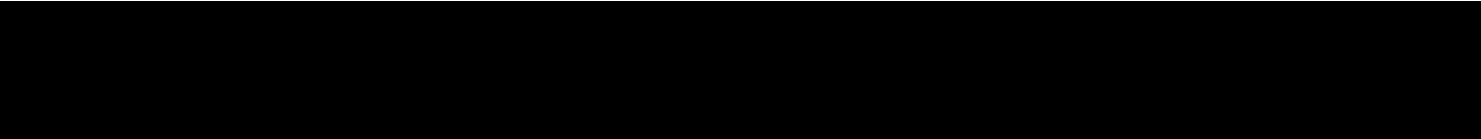
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1995 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2012 3. 2013 4. 2014 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 41	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 03/2014 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education 8th Grade or Less
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/22/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2000 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1996 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2005 2. 2014 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2002 2. 2008 3. 2007 4. 2014 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA COMPLETE		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2002 2. 2010 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/04/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
---	--	--

How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2006 2. 2015 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/04/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 01/30/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/19/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/13/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 03/2012 2. 11/2012 3. 4. 5. 6.

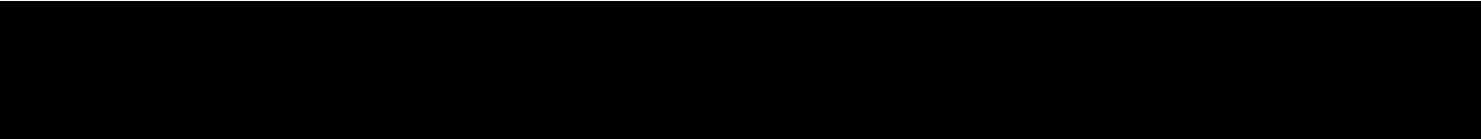
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2009 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 2013 3. 2015 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/17/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2011 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (in weeks) 11	Post fertilization age of the fetus (in weeks) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (number and street, city, state, and zip code) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (month, day, year): _____

DATE RECEIVED BY ISDH (month, day, year): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. UNKNOWN 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 2

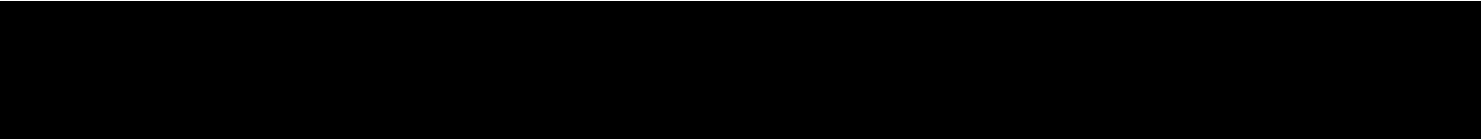
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 12/17/2014 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. _____ 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/26/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/25/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 40	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

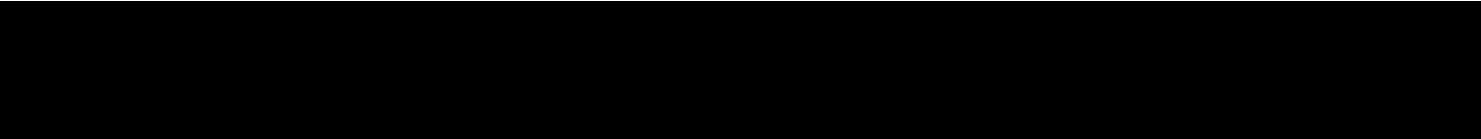
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/08/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/19/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2008 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/13/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2007 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2015 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/09/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA S OUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/01/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/18/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/20/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/06/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1999 2. 2016 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2014 3. 2014 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/14/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2010 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/25/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1998 2. 2000 3. 2015 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/28/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/05/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2004 2. 2010 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/09/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 2013 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2004 2. 2006 3. 2011 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/22/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		
Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/26/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 39	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1996 2. 2015 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/20/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 05/26/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2013	2. 2014	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 41	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. _____					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/27/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2010 3. 2010 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/13/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 10/18/2015 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PTROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/26/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/19/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MARSHALL DAVID LEVINE
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 200 N. MERIDIAN ST. STE 400, INDIANAPOLIS, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/03/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/04/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/28/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/02/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/19/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/29/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 4

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2014 2. 2015 3. UNKNOWN 4. UNKNOWN 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/22/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/07/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education Master's Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/12/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 02/16/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/14/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/29/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/16/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2001 2. 2002 3. 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/09/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 5	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2001 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/14/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2007 2. 2008 3. 2009 4. 5. 6.			
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/17/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/19/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2009 2. 2010 3. 2015 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/08/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/09/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 4	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 3

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1995 2. 1997 3. 2009 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 42	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 1996 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/04/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/01/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2013 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Bachelor's Degree
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Race <input checked="" type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/13/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 2013 3. 2015 4. 5. 6.		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/25/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/08/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/06/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/10/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/16/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

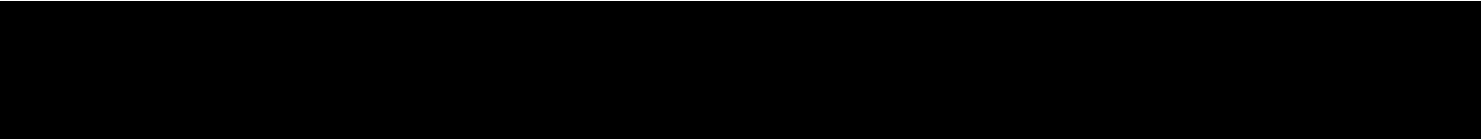
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2015	2. UNKNOWN	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)			
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:				
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE				
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/13/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 40	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1990 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/16/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2.	3.	4.	5.	6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>)
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	
		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/09/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

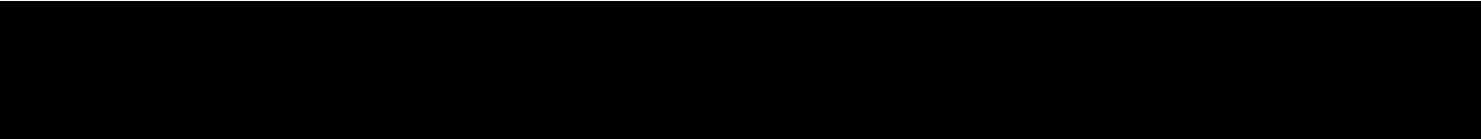
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/03/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/17/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 43	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/30/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2016 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/27/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 37	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/10/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/21/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2013 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/15/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/17/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/08/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/17/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/24/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/19/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/24/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/24/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 30	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 3	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2003 3. 2007 4. 2012 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/26/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 41	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2010 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/16/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/14/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. 2004	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 36	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/24/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. 2015 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/07/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 5	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 4	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. 2011 3. 2013 4. 2013 5. 2010 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/03/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2012 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/22/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 06/24/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2008 2. 2010 3. 2015 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/06/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/10/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/23/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 1
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2014 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/05/2016	Physician estimate of gestation (<i>in weeks</i>) 12	Post fertilization age of the fetus (<i>in weeks</i>) 10
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

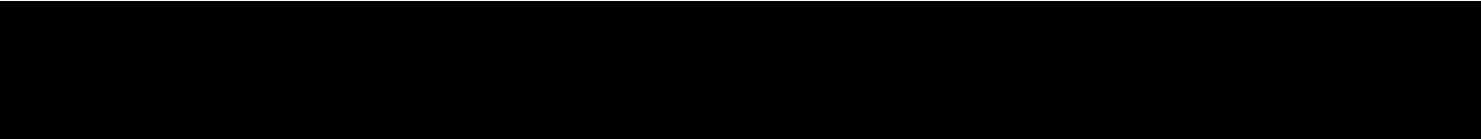
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 35	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education Master's Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results: PROCEDURE COMPLETE	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?
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Date last normal menses began 03/31/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
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How were the gestational age and post fertilization age determined? ULTRASOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/08/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 5	Number of induced terminations 2	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2011 2. UNKNOWN 3. UNKNOWN 4. UNKNOWN 5. UNKNOWN 6. UNKNOWN			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/06/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 22	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2016 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/24/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
<div>Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>	<div>Additional Procedure that Terminated Pregnancy</div> <div><input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>)</div> <div><input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>)</div> <div>For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?</div>

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <hr/> <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) <hr/> For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 5	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/07/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/26/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 39	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/29/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 3	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2013 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/07/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 21	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/15/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 16	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input checked="" type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/19/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/28/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began 05/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/15/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/25/2016	Education Bachelor's Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/18/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 31	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/25/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 2	Number of induced terminations 0

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>)					
1. UNKNOWN	2. UNKNOWN	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 32	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 2

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2004 2. 2011 3. UNKNOWN 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 29	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/25/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2012 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/15/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/25/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/29/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 17	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/25/2016	Education Some College, No Degree
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 05/09/2016	Physician estimate of gestation (<i>in weeks</i>) 5	Post fertilization age of the fetus (<i>in weeks</i>) 3
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. MANDY GITTLER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 8645 CONNECTICUT STREET, MERRILLVILLE, IN 46410

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/21/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 10	Post fertilization age of the fetus (<i>in weeks</i>) 8
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living	Number now deceased	
Other Terminations:	Number of spontaneous terminations	Number of induced terminations	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living	Number now deceased	
Other Terminations:	Number of spontaneous terminations	Number of induced terminations	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
-------------------------------	---	---

How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcsHOTlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
--	--	---

Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
-------------------------------	---	---

How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
-------------------------------	---	---

How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living	Number now deceased	
Other Terminations:	Number of spontaneous terminations	Number of induced terminations	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
---	--	---

Patient’s age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living	Number now deceased	
Other Terminations:	Number of spontaneous terminations	Number of induced terminations	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
-------------------------------	---	---

How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/12/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRASOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 43	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/18/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 2

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. UNKNOWN 2. UNKNOWN 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/05/2016	Physician estimate of gestation (<i>in weeks</i>) 11	Post fertilization age of the fetus (<i>in weeks</i>) 9
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education High School Diploma or GED
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 03/15/2016	Physician estimate of gestation (<i>in weeks</i>) 13	Post fertilization age of the fetus (<i>in weeks</i>) 11
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/25/2016	Physician estimate of gestation (<i>in weeks</i>) 6	Post fertilization age of the fetus (<i>in weeks</i>) 4
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 19	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/16/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient’s age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living	Number now deceased	
Other Terminations:	Number of spontaneous terminations	Number of induced terminations	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 27	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. UNKNOWN 2. UNKNOWN 3. 4. 5. 6.					
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/11/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 37	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 3	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 1998 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/16/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 33	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 24	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indian or Alaska Native <input checked="" type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. 2015 2. 3. 4. 5. 6.

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/18/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/20/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education Some College, No Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 1	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/17/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 34	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education Associate Degree
Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 2	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 1	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2015 2. UNKNOWN 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/27/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*):

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410	City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 25	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education 9th-12th, No Diploma
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 1	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 1	
Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. 2010 2. 3. 4. 5. 6.			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:		Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/02/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
How were the gestational age and post fertilization age determined? ULTRA SOUND		

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 28	Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education Bachelor's Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 2	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/12/2016	Physician estimate of gestation (<i>in weeks</i>) 9	Post fertilization age of the fetus (<i>in weeks</i>) 7
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age**	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation (<i>in weeks</i>)	Post fertilization age of the fetus (<i>in weeks</i>)
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How were the gestational age and post fertilization age determined? ULTRA SOUND
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Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): _____

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcs.hotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 26	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education 9th-12th, No Diploma
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 4	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 7	Post fertilization age of the fetus (<i>in weeks</i>) 5
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How were the gestational age and post fertilization age determined?
ULTRA SOUND

Full name of physician performing termination DR. JEFFREY D. GLAZER
Address of physician performing termination (<i>number and street, city, state, and zip code</i>) 1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219



**Date Reported to DCS, if Patient under 14 (*month, day, year*): _____

DATE RECEIVED BY ISDH (*month, day, year*): 07/27/2016

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov. Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year**. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(b).

Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 23	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/06/2016	Education Associate Degree
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased 0
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0

Dates of terminations (*Do not include this termination. If more than six (6), those most recent.*)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input checked="" type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began 04/01/2016	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined?
ULTRASOUND

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INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

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Facility Name and Address PLANNED PARENTHOOD OF MERRILLVILLE - 8645 CONNECTICUT STREET, MERRILLVILLE, IN, 46410		City or town, of pregnancy termination MERRILLVILLE	County of pregnancy termination LAKE
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Patient's age** 20	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 06/11/2016	Education High School Diploma or GED
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Race <input type="checkbox"/> American Indiana or Alaska Native <input type="checkbox"/> Asian <input checked="" type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input checked="" type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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Live Births:	Number now living 0	Number now deceased
Other Terminations:	Number of spontaneous terminations	Number of induced terminations

Dates of terminations (<i>Do not include this termination. If more than six (6), those most recent.</i>) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
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Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination <input type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (<i>Specify</i>) _____ Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:	
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:	

Type of Termination Procedures	
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Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (<i>Specify</i>) _____ <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (<i>Specify</i>) _____ For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? _____
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Date last normal menses began UNKNOWN	Physician estimate of gestation (<i>in weeks</i>) 8	Post fertilization age of the fetus (<i>in weeks</i>) 6
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How were the gestational age and post fertilization age determined? ULTRASOUND

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